



GEORGIA MEDICAID FEE-FOR-SERVICE ANTIBIOTICS, GI PA SUMMARY

Preferred	Non-Preferred
Metronidazole tablets generic Neomycin generic Vancomycin generic	Dificid (fidamoxacin) Paromomycin generic Xifaxan (rifaximin)

LENGTH OF AUTHORIZATION: Varies

PA CRITERIA:

Dificid

- ❖ Approvable for members 18 years of age or older for the treatment of clostridium-difficile-associated diarrhea (C. difficile)

AND

- ❖ For severe cases, member must have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to vancomycin

OR

- ❖ For mild-to-moderate cases, member must have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to metronidazole and vancomycin.

Paromomycin

- ❖ Approvable for members with a diagnosis of intestinal amebiasis (*Dientamoeba fragilis*, *Entamoeba histolytica*) including asymptomatic intestinal colonization who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to metronidazole or tinidazole.
- ❖ Approvable for members 18 years of age or older a diagnosis of hepatic coma or hepatic encephalopathy when being used to suppress intestinal bacterial growth and the member has experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to neomycin.
- ❖ Approvable for members with a diagnosis of cryptosporidiosis (*Cryptosporidium parvum*) in human immunodeficiency virus (HIV)-infected patients who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to nitazoxanide (Alinia) and when used in combination with antiretroviral therapy (ART), symptomatic treatment, rehydration and electrolyte replacement.

Xifaxan

- ❖ Approvable for members 12 years of age or older with a diagnosis of traveler's diarrhea who have experienced inadequate response, allergies, contraindications, drug-drug interactions or intolerable side effects to at least two of the following preferred products: ciprofloxacin, ofloxacin and azithromycin.



- ❖ Approvable for members 18 years of age or older with a diagnosis of hepatic encephalopathy who are taking lactulose or have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to lactulose.
- ❖ Approvable for a diagnosis of irritable bowel syndrome with diarrhea in members 18 years of age or older who have experienced inadequate response, allergy, contraindication, drug-drug interaction or intolerable side effect to loperamide or alosetron (Lotronex).

EXCEPTIONS:

- Exceptions to these conditions of coverage, including initiation of therapy with non-preferred agents while in the hospital, are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827**.

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to <http://dch.georgia.gov/preferred-drug-lists>.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on [Other Documents](#), then select the most recent quarters QLL List.